KIDBASE

Kids' Information Database Access System for Emergencies

Helping emergency personnel care for your child with special health care needs

Photograph of Child (optional)

For questions about KIDBASE, please email Kid.Base@ncmail.net or call (919) 855-3935.

Keep copies of this form with: (1) Your Child in backpack/on wheelchair; (2) School Nurse or Teacher; (3) Daycare; (4) Any other person your child is with frequently.

Please keep this form updated as your child's medical information and/or care changes. An electronic copy of this form, which allows you to easily update and save your child's medical information, can be found at www.ncems.org/kidbase.htm. Once the form has been completed, send the KIDBASE postcard to your KIDBASE coordinating agency or contact them directly to let them know your child is enrolled.

PARENT/GUARDIAN

Instructions: *Parent/Guardian fills out this section.*
(Consider contacting your child's physician if you need help filling out this section.)

CHILD'S NAME: _____ (LAST NAME) _____ (FIRST NAME) NICKNAME: _____

DATE OF BIRTH: ____/____/____ (mm/dd/yyyy) ☐ MALE ☐ FEMALE CURRENT WEIGHT: _____kgs HEIGHT: _____

HOME ADDRESS: _____ (STREET NAME or P.O. BOX) (APT. #) (CITY) (STATE) (ZIP CODE)

MAILING ADDRESS: _____ (IF DIFFERENT THAN HOME ADDRESS) (STREET NAME or P.O. BOX) (APT. #.) (CITY) (STATE) (ZIP CODE)

NAME OF PARENT(S)/PRIMARY CAREGIVER(S): _____

PREFERRED CONTACT PHONE NUMBER: _(____)_____ EMAIL ADDRESS: _____ (IF APPLICABLE)

Emergency Contact Information (Other than Parent/Primary Caregiver)

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO CHILD: _____ PREFERRED CONTACT PHONE NUMBER: _(____)_____

PRIMARY CARE PHYSICIAN: _____

OFFICE PHONE: _(____)_____ EMERGENCY PHONE: _(____)_____

PREFERRED SPECIALTY PHYSICIAN: _____ SPECIALTY: _____

OFFICE PHONE: _(____)_____ EMERGENCY PHONE: _(____)_____

PRIMARY LANGUAGE: _____ COMMUNICATION/LEVEL OF FUNCTION: ☐ VERBAL ☐ NONVERBAL

HEARING IMPAIRED: ☐ YES ☐ NO LEGALLY BLIND: ☐ YES ☐ NO ABLE TO WALK: ☐ YES ☐ NO ABLE TO SPEAK: ☐ YES ☐ NO

ANY COGNITIVE/MENTAL DIFFICULTIES: ☐ YES ☐ NO ANY SENSORY ISSUES: ☐ YES ☐ NO

CAN HE OR SHE BE UNDERSTOOD BY OTHERS?: ☐ YES ☐ NO CAN HE OR SHE UNDERSTAND OTHERS?: ☐ YES ☐ NO

DOES ANYTHING IN PARTICULAR UPSET OR OVERSTIMULATE YOUR CHILD?: _____
EXAMPLE: bright lights, loud noises, medical equipment, touch, etc.

PHYSICIAN

Instructions: *Child's Physician fills out this section.*
Please print or type.

CHILD'S DIAGNOSES: _____

CHILD'S PAST PROCEDURES: _____

cont. on back

PHYSICIAN cont.

Baseline Vital Signs

DNR STATUS: _____ SKIN COLOR: _____

PULSE RATE: _____ _____ (SITE BEST TAKEN) BLOOD PRESSURE: _____ _____ (SITE BEST TAKEN)

RESPIRATORY RATE: _____ _____ (BREATH SOUNDS) PULSE Ox ROOM AIR: Pulse Ox on _____ liter/min Oxygen

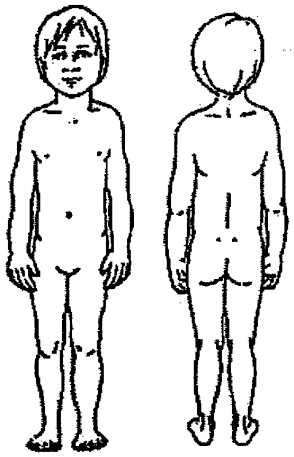
BROSELOW RESUSCITATION TAPE COLOR: _____ WEIGHT (Kgs) _____ BLOOD SUGAR LEVEL: _____

TEMPERATURE: _____ _____ (HOW TAKEN) PUPILS: _____

OTHER SIGNIFICANT BASELINE FINDINGS *(lab, x-ray, ECG, EKG, etc.)*: _____

Instructions:

Shade areas of paralysis or diminished sensation. Denote the location of Venous Access Devices.



Special Technologies/Devices

☐ NEBULIZER ☐ TRACHEOSTOMY ☐ VENTILATOR

☐ CENTRAL VENOUS CATHETER, IMPLANTED PORT, OR OTHER VENOUS ACCESS DEVICE (denote on diagram)

☐ PACEMAKER ☐ VENTRICULAR PERITONEAL SHUNT ☐ DIALYSIS SHUNT ☐ OSTOMY STOMA

☐ GASTROSTOMY TUBE OR BUTTON Size: _____

☐ VAGAL NERVE STIMULATOR ☐ OTHER (Describe): _____

Special Equipment Used to Care for this Child

☐ CONTINUOUS OXYGEN Rate and Route: _____ ☐ VENTILATOR, Vent Settings: _____

☐ BAG VALVE, Size: _____ ☐ WITH MASK, Mask Size: _____

☐ TRACH TUBE, Size: _____ ☐ IV ACCESS LOCATION, Needle Type & Size: _____

☐ SUCTION CATHETER, Size: _____

☐ OTHER SPECIAL CONSIDERATIONS (i.e, Past Successful Interventions): _____

Any special transportation requirement such as position of comfort or wheelchair?

Allergies (List all and indicate child's reaction to each.)

☐ MEDICATIONS: _____

MEDICATIONS TO AVOID: _____

☐ FOODS: _____ ☐ LATEX: _____

Medications

DRUG NAME	DOSAGE	WHEN/HOW TAKEN	SIDE EFFECTS/SPECIAL INSTRUCTIONS

PHYSICIAN/PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____

I have reviewed the information contained in this document and consent to the information being made available to emergency care personnel to prepare for and assist my child during an emergency. I understand that it is my responsibility to update this form when my child has siginificant changes in his medical condition and/or care. I also understand that this information will be kept confidential and only shared with emergency care providers that may be asked to care for my child during an emergency.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PRINT NAME: _____